Chronic Care Management

Critical Access Hospital Administrator's Meeting

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Resources/Sources

- **Department of Health and Human Services Chronic Care Management Services ICN 909188 May 2015**
- **Department of Health and Human Service Transitional Care Management Services ICN 908628 March 2016**
- **CMS Frequently Asked Questions about Billing the Medicare Fee Schedule for Transitional Care Management Services March 17, 2016**
- **CMS Frequently Asked Questions about Billing Medicare for Chronic Care Management Services March 17, 2016**
- **CMS Chronic Care Management (CCM) Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions February 19, 2016**
- **CMS Manual System Transmittal 1576 Change Request 9234 November 18, 2015**

Why are We Here?

Physicians and health care providers continue to improve quality of care, lower costs
Affordable Care Act Accountable Care Organization initiatives put patients at the center of their care while ***generating more than $1.29 billion in total Medicare savings since 2012***

The Centers for Medicare & Medicaid Services (CMS) today announced the 2015 performance year results for the Medicare Shared Savings Program and the Pioneer Accountable Care Organization Model that show physicians, hospitals, and health care providers participating in Accountable Care Organizations continue to make significant improvements in the quality of care for Medicare beneficiaries, while achieving cost savings. Collectively, Medicare Accountable Care Organizations have generated more than $1.29 billion in total Medicare savings since 2012.

*https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-08-25.html

Hospital Operations 101

Hospitals not operating at efficient levels are currently, or will be, struggling financially

"Efficient" is defined as

- Appropriate patient volumes meeting needs of their service area
- Revenue cycle practices operating with best practice processes
- Expenses managed aggressively
- Physician practices managed effectively
- Effective organizational design

Hospital Operations 101

- Develop LEAN production practices that consider the expenditure of resources for any goal other than the creation of value for the end customer to be wasteful
    - Preserving value / quality with less processes
    - Workflow redesign
    - Inventory Levels / Standardization
    - Response Times
    - Replicating Successes among all hospitals
    - C-Suite training on LEAN / Six Sigma
- Evaluate 340B discount pharmacy program as an opportunity to both increase profit and reduce costs
    - Often 340B is only looked upon as an opportunity to save costs not considering profit potential

Arkansas Lean Project

- **Lean Efficiency Training**

The consultants facilitated on-site staff training for Lean at three rural hospitals in Arkansas. Sessions focused on the hospital's department managers and staff with the goal to educate participants in the LEAN process and identify a variety of issues that each group can utilize the LEAN process to initiate change in the organization.

- **Objectives:**
  - Eliminate waste
  - Reduce cost
  - Improve patient satisfaction

Arkansas Lean Project

The following summary includes highlights from each hospital and session evaluations were included in the report to each facility including participant's feedback. Evaluations included nine total questions to gauge participant feedback. 216 total staff were trained at the three hospitals through this project and evaluation highlights included:

- **94% of participants felt the handouts were helpful**
- **93% of participants felt the training met their expectations**
- **97% of participants felt the group sessions were helpful**

Arkansas Lean Project

Other Areas Identified:

Communication was discussed in all sessions. This involved inter-departmental communication as well as hospital-wide communication.

Over utilization of the e-mail system was identified by all groups. Broadcast e-mail and copying unnecessary personnel on emails should be minimized. In lost productivity, the managers are wasting at a minimum, $80,000 per year in time processing unnecessary emails.

Training, professionalism and turnover were discussed by more than one department. This included internal staff transfers and outmigration.

Lab turn-around times were also discussed

IT staff are not involved in technology purchases causing complications and rework

EMR systems used in various departments are not integrated into Evident/CPSI.

Arkansas Lean Project

By coincidence all the participating hospitals used CPSI as the EMR system and the consultants suggested the hospitals work together to streamline issues related to the integration of EMR. There were areas that affected all the hospitals that included:

- *Medical staff lack of utilization of EMR*
- *Staff time wasted tracking down paperwork for signature and billing processes*
- *EMR's not being used to fullest capability*
- *"Add-on" departmental software not being integrated into main EMR*

Hospital Operations 101

Structure physician compensation agreements to build quality measures into incentive based contracts

- Modify Medical Staff bylaws tying incentives around quality and outcomes into them
- Ensure most appropriate methods are used to capture HCAHPS survey data
  - Consider transitioning from paper survey to phone call survey to ensure that method has increased statistical validity
- Electronic Health Record (EHR) to be used as backbone of quality improvement initiative
  - Meaningful Use – Should not be the end rather the means to improving performance
- Increase Board members understanding of quality as a market differentiator
  - Move from reporting to Board to engaging them (i.e. placing board member on Hospital Based Quality Council)

Quality = Performance Excellence

Hospital Operations 101

- Grow patient volume to meet community needs
  - Opportunities often include:
    - ER Admissions
    - Swing bed
    - Ancillary services (imaging, lab, ER, etc.)
- Increase efficiency of revenue cycle function
  - Adopt revenue cycle best practices
    - Effective measurement system
    - "Super charging" front end processes including online insurance verification, point of service collections
    - Education on necessity for upfront collections
    - Ensure charge master is up to date and reflects market reality
- Continue to seek additional community funds to support hospital mission
  - Increase tax base where appropriate and ensure tax renewals

CAH GOALS

Have an effective organizational design that drives accountability into the organization!

- Decision Making
  - Drive decision rights down to clinical/operation level
  - Education to department managers on business of healthcare
- Avoid separation of clinical and financial functions
- Increase (Start) Performance Measurement
- Department managers should be involved in developing annual budgets
  - “Budget compared to actual” reports to be sent to department managers monthly
  - Variance analysis to be performed through regularly scheduled meetings between CFO/CEO and department managers
- Compensation
  - Recognize performance in line with organizational goals

CCM and The Future of Rural Healthcare

By meeting quality performance standards and their savings threshold, 125 Accountable Care Organizations qualified for shared savings payments. Since the passage of the Affordable Care Act, more than 470 Medicare Accountable Care Organizations – serving nearly 8.9 million Medicare beneficiaries – have been established through the Medicare Shared Savings Program, the Pioneer Accountable Care Organization Model, the Next Generation Accountable Care Organization Model, and the Comprehensive End-Stage Renal Disease Care Model.

"Accountable Care Organization initiatives in Medicare continue to grow and achieve positive results in providing better care and health outcomes while spending taxpayer dollars more wisely," said Dr. Patrick Conway, CMS Principal Deputy Administrator and Chief Medical Officer. "CMS continues to work and partner with providers across the country to improve the way health care is delivered in the United States."

*https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-08-25.html

CCM Background

Effective January 1, 2015 implementation of CCM for Medicare Fee for Service providers

Effective January 1, 2016 CMS regulations allow for CCM service in RHCs and FQHCs

Reimbursement under Medicare Physician Fee Schedule

- CPT Code 99490

Quality

- Patients managed under CCM will lead to improvement in quality scores and provide an overall reduction in healthcare spending

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CCM Requirements

Patients with two or more chronic conditions:

- Lasting for the next twelve months, or
- Until death of patient

These conditions would place the patient at significant risk of death, exacerbation or functional decline

CMS maintains a Chronic Condition Warehouse (CCW)

- www.ccwdata.org

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CCM Consent

Prior to providing CCM services, clinic will need to obtain written consent

Consent includes:

- Nature of CCM
- How CCM was assessed
- One provider at a time to furnish CCM
- Health information will be shared with other providers for care
- Patient may stop CCM at any time by revoking
- Patient is responsible for co-insurance/deductibles

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CCM Providers

Majority of CCM services are directed by:

- Primary Care Providers: MD, DO, NP, PA
- Specialists: Only if providing the majority of the services
- Clinical staff can assist
  - RN
  - LPN
  - CMA
  - Pharmacists
  - Technicians
  - Therapists

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CCM Providers

CMS has indicated that "other staff may help facilitate CCM services but only time spent by clinical staff may be counted towards the 20 minute minimum time".

20 minutes of non face-to-face per encounter per month:

- Certified healthcare professional under general supervision of PCP
- "Incident-to" exceptions to include provider does not need to be in the same location as the professional providing coordination
  - Exception: RHC/FQHC

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CCM Requirements

Direct Supervision in RHC/FQHC:

- Requires that RHC/FQHC practioners be present in the RHC/FQHC and immediately available to furnish assistance and direction
- The RHC/FQHC practioners does not need to be present in the room when the service is furnished
- There is no exception to the direct supervision requirement at this time for CCM services furnished by “auxiliary staff” in RHCs/FQHCs

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CCM Requirements

Structured recordings of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record:

- Using a certified EHR
- Not required to be a “meaningful user” of the technology but is required to utilize elements of the EHR technology “using certified technology”

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CCM Requirements

Clinical summary record:

- Provider's name and office contact information
- Date and location of visit
- Reason for visit
- Immunizations/medications administered during visit
- Diagnostic tests
- Clinical instructions
- Future appointments and scheduled tests
- Referrals to other providers
- Recommended patient decision aids

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CCM Requirements

The provider must be able to transmit the summary care record electronically for purposes of care coordination. CMS does not specify acceptable methods of transmission but does state that facsimile transmission IS NOT ACCEPTABLE.

- This is not to say that you cannot transmit via fax, but that if you do not have a means to electronically transmit, you will not meet the requirements of CCM

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CCM Requirements

- Comprehensive Plan of Care:
  - Physical – body
  - Mental – brain
  - Cognitive – understanding
  - Psychosocial – interactions
  - Functional – abilities
  - Environmental – surroundings
- A current list of providers that are involved in providing medical care
- An assessment of patient's preventative healthcare needs
- Plan should address all health issues (not just chronic conditions)
- Applicable to patient's choices

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CCM Requirements

Comprehensive Plan of Care: (Continued)

- Problem list
- Medication Management
- Expected outcomes and prognosis
- Measurable treatment goals
- Symptom management and planned interventions

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CCM Requirements

The preparation and updating of this care plan is not part of a reimbursable visit for CCM services

- This will be billed separately as an evaluation and management service, annual wellness visit, or an initial preventative physical exam
- The plan, once developed, will need to be updated annually

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CCM Requirements

24/7 access to care management services

- Patient to access a member of the care team
- Remote access, web based access

Contact with a healthcare provider for urgent chronic needs

- ***Regardless of time of day or night***

Access to a designated practioner with whom the patient is able to get routine successive appointments

- Continuity of care with provider team

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CCM Requirements

Management of care transitions examples include:

- Referrals
- Emergency Department
- Inpatient Stay
- Skilled Nursing Facility

Transitional Care Management (TCM) services and CCM cannot be billed during the same month

Coordination of home and community based service providers to support psychosocial needs and functional deficits

- Document as CCM service:
  - Home Health
  - Hospice
  - Outpatient therapy
  - Durable Medical Equipment
  - Transportation Services
  - Nutritional Services

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CCM Requirements

Opportunity for patient and any relevant caregiver to communicate with provider via:

- Phone
- Secure Messaging
- Internet

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CCM Consent

Document the beneficiary's written consent and authorization in the EHR using CCM certified technology

- Inform beneficiaries in advance of their eligibility for CCM, documenting the explanation and offer
- Document written informed consent (or decline), including permission to electronically share relevant medical information with other providers
- Inform of the right to discontinue CCM, verbally, or in writing, at any time (effective at the end of the service period) and the effect of revoking the agreement
- Inform that only one practioners can furnish and be paid by Medicare for CCM within a service period
- Inform that cost sharing applies
- **Retroactive consent is not allowed**

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CCM Documentation Details

Medication Reconciliation

Medication Management (refills)

Completion of forms (DME)

Coordination of Care – Referrals

Date of service CCM provided

Time (start and stop)

Name of individual providing serve and credentials

Description of service provided

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Prior to CCM Billing

Make sure patient is seen by a provider prior to starting CCM billing

Obtain an informed written consent for CCM services; let them know 20% co-insurance applies

Explain to patient they can only be enrolled with one provider for CCM within the calendar period – provide information on how they can revoke consent

Document in patient's medical record that they opted to accept or decline CCM services

Ensure patient receives a copy of consent and care plan; documented in medical record

Documentation of the 20 minutes cumulative non face-to-face encounters.

- Phone calls
- Emails with patient
- Medication reconciliation, prescription management
- Time spent coordinating care and resources

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Prior to CCM Billing

Ensure that all elements for calendar month are met prior to billing CPT code 99490

Avoid duplicate billing for Transitional Care Management (TCM) or Telemedicine billing codes in the same month

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RHCs and FQHCs

Beginning January 1, 2016, RHCs and FQHCs may receive an additional payment for the costs of CCM services that are not already captured in the RHC all-inclusive rate or the FQHC prospective payment system (PPS) rate for CCM services to Medicare beneficiaries

Can bill for CCM services when a practioners furnishes a comprehensive evaluation and management (E&M) visit, Annual Wellness Visit (AWV), or an Initial Preventative Physical Examination (IPPE) to the patient prior to billing the CCM service and initiate the CCM service as part of the visit

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RHCs and FQHCs

The Direct Supervision Requirement applies for the 20 minute non face-to-face

Payment for this service is based on the Medicare PFS national average non-facility payment rate when CPT code 99490 is billed alone wo with other payable services in an RHC or FQHC claim

Coinsurance will be applied as applicable to FQHC claims

Coinsurance and deductibles would apply as applicable to RHC claims

The rate for CPT code 99490 will be updated annually and has no geographic adjustment

2016 rate is $40.82

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RHCs and FQHCs

RHC and FQHC face-to-face requirements are waived when CCM services are furnished to a RHC/FQHC patient

Cannot bill for CCM services for a beneficiary during the same period as billing for transitional care management (TCM) or any other program that provides additional payment for care management services for the same patient

Billing for CCM services:

- UB-04
- Revenue Code 52X
- CPT Code 99490
- Date of service is the date that 20 minutes of non face-to-face has been met or any date after that prior to the end of the month

Return on Investment

Scenario

- Reimbursement is $40.82 per patient, per month
- 150 Medicare FFS patients qualify for CCM

  $489.84 per patient, per year

  X 150 CCM patients

  $73,476 Total Revenue

- 1.0 FTE for Care Coordinator $40-$50,000/year
- ROI = $23,476 - $33,476 per year

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CCM Results

CCM billing income to cover Care Coordinator

Increased revenue for the clinic

Increase in patient visits

Effective care coordination to improve patient outcomes and reduce costs

Needed to participate in value based payment models in the future

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Annual Wellness to CCP

RHC's

- Annual wellness visits (AWV) may be billed as a visit if it is the only medical service on that day with an RHC practioner
- If AWV is furnished on the same day as a medical visit, it is not separately billable as an RHC visit
  - IPPE is separately billable

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Considerations

Medical necessity

- Two or more chronic conditions

RHC multiple visit regulations

- AWV and medical = 1 billable visit
- IPPE and medical = 2 billable visits
- Mental and medical = 2 billable visits

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Next Steps!

- Considerations to go to the next level
  - A facility “operational assessment” to evaluate business office, operations and staffing levels
  - Revenue cycle management review
  - Charge master review
  - Contract review (commercial payers)
  - Lean training for all staff
  - Implementation of PCMH
  - Implementation of CCM

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QUESTIONS???

THANK YOU!

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